CoverTN Funding Summary

4/18/2006

Program	Source of Funds	Notes	State Funding FY07	FY08	FY09	3 Year Total State Funding
CoverTN	Portion of TennCare Reserves	State Dollar reserves that were originally set aside against contingent federal claims that the state successfully settled.	$9 million	$24 million	$67 million	$100 million
AccessTN*	Portion of recurring Safety Net funds	Existing Safety Net funds: F&A Recurring	$3.8 million	$10 million	$10 million	$24 million
CoverKids	Ongoing TennCare savings	$4M in funds were specifically set aside to expand coverage for children in TennCare's original proposed FY07 budget. Will now be redirected for SCHIP.	$7 million	$18 million	$35 million	$60 million
CoverRx*	Portion of recurring Safety Net funds	Existing Safety Net funds: F&A Recurring	$23 million	$16.8 million	$16.8 million	$57 million
Project Diabetes	Portion of Safety Net recurring funds	Existing Safety Net funds: F&A Recurring	$15 million	$15 million	$15 million	$45 million
			57.8	83.8	143.8	

** Additionally, the Administration has proposed a Reserve fund of $18 million for AccessTN and CoverRx to be paid out of the Safety Net F&A FY06 Carry Forward.*

HRSA

WEST VIRGINIA STATE PLANNING GRANT

AFFORDABLE INSURANCE WORKGROUP

REPORT AND RECOMMENDATIONS

DECEMBER 2005

HEALTH CARE AUTHORITY West Virginia Health Care Authority

West Virginia INSTITUTE FOR HEALTH POLIC

Individual Health Access Plan - OPTION A

General Provisions for Medical & Surgical Services	
Annual Deductible	$250 * Does not apply to preventive services listed above
Physician Services	
Adult routine physical examinations	Limit of $2000 for ***ALL*** outpatient services per year
Diagnostic x-ray, lab and testing	
Physician inpatient visits	
Physician office visits	
Prenatal care	
Well child exams and immunizations	
Hospital Inpatient Services	
Semiprivate room; ancillaries; therapy, maternity, x-ray, lab, surgical, and general nursing services	Hospital inpatient ***NOT COVERED***
Rehabilitation	
Skilled nursing	
Maternity Care	***Covered at limit of $2000 for ALL outpatient services per year***
Hospital Outpatient Services	
Outpatient surgery	Limit of $2000 for ***ALL*** outpatient services per year
Preadmission testing; diagnostic, x-ray and lab; radiation and chemotherapy	
Mental Health & Chemical Dependency	
Inpatient services, including detoxification and partial hospitalization	Limit of $2000 for ***ALL*** outpatient services per year
Outpatient services	
Outpatient Therapy	

Acupuncture; occupational, physical, and speech therapy	Limit of $2000 for ***ALL*** outpatient services per year
Chiropractic services	Not covered
Other Medical Services	
Emergency room treatment	Limit of $2000 for ***ALL*** outpatient services per year
Emergency services and supplies	
Durable medical equipment	
Infertility services	Not covered
Other medical services and supplies (if not covered under prescription drug benefit)	Limit of $2000 for ***ALL*** outpatient services per year
Podiatry	Limit of $2000 for ***ALL*** outpatient services per year
Dental services / TMJ	Not covered; except for treatment related to accidents or impacted teeth then Limit of $2000 for ***ALL*** outpatient services per year
Hearing exam	Not covered (except under well child benefit)
Vision services	Not covered
General Provisions for Prescription Services	
Prescription Drugs are NOT COVERED	

Acupuncture; occupational, physical, and speech therapy	Limit of $2000 for ***ALL*** outpatient services per year
Chiropractic services	Not covered
Other Medical Services	
Emergency room treatment	Limit of $2000 for ***ALL*** outpatient services per year
Emergency services and supplies	
Durable medical equipment	
Infertility services	Not covered
Other medical services and supplies (if not covered under prescription drug benefit)	Limit of $2000 for ***ALL*** outpatient services per year
Podiatry	Limit of $2000 for ***ALL*** outpatient services per year
Dental services / TMJ	Not covered; except for treatment related to accidents or impacted teeth then Limit of $2000 for ***ALL*** outpatient services per year
Hearing exam	Not covered (except under well child benefit)
Vision services	Not covered
General Provisions for Prescription Services	
Prescription Drugs are NOT COVERED	

Individual Health Access Plan - OPTION A

Estimated Average Single Premium = $95.85/per month

Option A	Estimated Monthly Rates	
Age Band	Male	Female
19-25	$41.59	$53.38
26-34	$46.45	$71.28
35-44	$61.94	$88.35
45-54	$106.63	$117.25
55-64	$180.07	$158.83

Individual Health Access Plan - OPTION B

General Provisions for Medical & Surgical Services	
Annual Deductible	$250 * Does not apply to preventive services listed above
Physician Services	
Adult routine physical examinations	Limit of $2000 for ***ALL*** outpatient services per year
Diagnostic x-ray, lab and testing	
Physician inpatient visits	
Physician office visits	
Prenatal care	
Well child exams and immunizations	
Hospital Inpatient Services	
Semiprivate room; ancillaries; therapy, maternity, x-ray, lab, surgical, and general nursing services	Hospital inpatient ***NOT COVERED***
Rehabilitation	
Skilled nursing	
Maternity Care	***Covered at limit of $2000 for ALL outpatient services per year***
Hospital Outpatient Services	
Outpatient surgery	Limit of $2000 for ***ALL*** outpatient services per year
Preadmission testing; diagnostic, x-ray and lab; radiation and chemotherapy	
Mental Health & Chemical Dependency	
Inpatient services, including detoxification and partial hospitalization	Limit of $2000 for ***ALL*** outpatient services per year
Outpatient services	
Outpatient Therapy	

Acupuncture; occupational, physical, and speech therapy	Limit of $2000 for ***ALL*** outpatient services per year
Chiropractic services	Not covered
Other Medical Services	
Emergency room treatment	Limit of $2000 for ***ALL*** outpatient services per year
Emergency services and supplies	
Durable medical equipment	
Infertility services	Not covered
Other medical services and supplies (if not covered under prescription drug benefit)	Limit of $2000 for ***ALL*** outpatient services per year
Podiatry	Limit of $2000 for ***ALL*** outpatient services per year
Dental services / TMJ	Not covered; except for treatment related to accidents or impacted teeth then Limit of $2000 for ***ALL*** outpatient services per year
Hearing exam	Not covered (except under well child benefit)
Vision services	Not covered
General Provisions for Prescription Services	
Annual Deductible	$75
Covers Generic Drugs ONLY	24 prescriptions per year are covered
NO COVERAGE for BRAND Drugs	

Individual Health Access Plan - OPTION B

Estimated Average Single Premium = $110.89/per month

Option B	Estimated Monthly Rates	
Age Band	Male	Female
19-25	$48.54	$62.29
26-34	$54.21	$83.19
35-44	$72.29	$103.10
45-54	$124.44	$136.83
55-64	$210.15	$185.36

Individual Health Access Plan - OPTION C

General Provisions for Medical & Surgical Services	
Annual Deductible	$250 * Does not apply to preventive services listed above
Physician Services	
Adult routine physical examinations	Limit of $2000 for ***ALL*** outpatient services per year
Diagnostic x-ray, lab and testing	
Physician inpatient visits	
Physician office visits	
Prenatal care	
Well child exams and immunizations	
Hospital Inpatient Services	
Semiprivate room; ancillaries; therapy, maternity, x-ray, lab, surgical, and general nursing services	Hospital inpatient covered for (3) days
Rehabilitation	
Skilled nursing	
Maternity Care	
Hospital Outpatient Services	
Outpatient surgery	Limit of $2000 for ***ALL*** outpatient services per year
Preadmission testing; diagnostic, x-ray and lab; radiation and chemotherapy	
Mental Health & Chemical Dependency	
Inpatient services, including detoxification and partial hospitalization	Limit of $2000 for ***ALL*** outpatient services per year
Outpatient services	
Outpatient Therapy	

Acupuncture; occupational, physical, and speech therapy	Limit of $2000 for ***ALL*** outpatient services per year
Chiropractic services	Not covered
Other Medical Services	
Emergency room treatment	Limit of $2000 for ***ALL*** outpatient services per year
Emergency services and supplies	
Durable medical equipment	
Infertility services	Not covered
Other medical services and supplies (if not covered under prescription drug benefit)	Limit of $2000 for ***ALL*** outpatient services per year
Podiatry	Limit of $2000 for ***ALL*** outpatient services per year
Dental services / TMJ	Not covered; except for treatment related to accidents or impacted teeth then Limit of $2000 for ***ALL*** outpatient services per year
Hearing exam	Not covered (except under well child benefit)
Vision services	Not covered
General Provisions for Prescription Services	
Annual Deductible	$75
Covers Generic Drugs ONLY	12 prescriptions per year are covered
NO COVERAGE for BRAND Drugs	

Individual Health Access Plan - OPTION C

Estimated Average Single Premium = $157.41 per month

Option C	Estimated Monthly Rates	
Age Band	Male	Female
19-25	$70.09	$89.96
26-34	$78.29	$120.13
35-44	$104.39	$148.89
45-54	$179.70	$197.60
55-64	$303.48	$267.68